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ABSTRACT

Clients seeking psychological counseling, who initiate service of their own volition, do so to obtain help with a problem that they feel afflicts them. Counselors' perceptions of clients' presenting problems assist counselors in making predictions about behavior from which they construct treatment plans. Research has demonstrated that incongruity between counselor and client perceptions may adversely affect the counseling process and outcome. This study compared client and counselor perceptions of clients' presenting problems within the structure of a counselor training clinic, which serves a large number of community residents presenting real life problems. Participants (N=265) were clients of a university counselor training center. Intake counselors (N=6) were psychologists-in-training who were completing the last few weeks of their residency requirement, including a supervised internship experience. Discrepancies were found between community mental health clients' and their intake counselors' perceptions of clients' presenting problems. Counselors and clients similarly identified "family problems" and "marital problems." Counselors were less aware of clients' "specific anxiety" and their problems in "thinking clearly." Counselors more often identified "intrapersonal problems" and "interpersonal problems" than did clients. In view of these results and the scarcity of research the need for additional study in this area is indicated. (Author/ABL)

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A Comparison of Intake Counselors' and Clients' Perceptions of Clients' Presenting Problems

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Running Head: A COMPARISON OF PERCEPTIONS

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Abstract

A Comparison of Intake Counselors' and Clients' Perceptions
of Clients' Presenting Problems

Discrepancies were found between 265 community mental health clients' and their intake counselors' perceptions of clients' presenting problems. These clients had requested counseling at an outpatient counselor training clinic. Intake counselors were six psychologists-in-training who were completing the last few weeks of their residency requirement, including a supervised internship experience. Counselors and clients similarly identified "family problems" and "marital problems." Counselors were less aware of clients' "specific anxiety" and their problems in "thinking clearly." Counselors more often identified "intrapersonal problems" and "interpersonal problems" than did clients. Implications for practitioners are noted.

A Comparison of Intake Counselors' and Clients' Perceptions of Clients' Presenting Problems

Clients seeking psychological counseling, who initiate service of their own volition, do so to obtain help with a problem that they feel afflicts them. Counselors' perceptions of clients' presenting problems assist counselors in making predictions about behavior from which they construct treatment plans (Callis, 1965). According to Hurst, Weigel, Thatcher, and Nyman (1969), the accuracy of these perceptions and the subsequent predictions are frequently critical in the handling of cases.

Differing perceptions of presenting problems from clients' and counselors' perspectives can lead to different treatment goals for each party. A number of studies, spanning the past four decades, have demonstrated that incongruity of goals between counselor and client may adversely affect the counseling process and outcome (Rogers, 1951; Lennerd & Bernstein, 1960; Landfield, 1965; Luborsky, Chandler, Averback, & Cohen, 1971; Sirles, 1982). Sirles (1982) also notes that the amount of agreement between the client and the counselor in identifying the presenting problem has serious implications for the assessment of treatment outcome.

Incorrect perceptions of clients' presenting problems by counselors at intake may also result in misleading expectations on the part of the client regarding treatment outcome. Luborsky et al. (1971), in their review of outcome research, suggested that high initial levels of affect are indicators of good prognosis in therapy. They stressed the importance of accurately assessing clients' initial affect levels and not overestimating clients' levels of pathology. These researchers observed that a good outcome more often followed when the patient and therapist were able to reach a mutual understanding regarding solution of the patient's problems. It seems that this helping alliance would certainly be facilitated by counselor and client agreement regarding perceptions of

the clients' presenting problems and would consequently have a direct impact on both treatment plans and on the outcome of therapy.

Need for the Study

The present study was conducted in order to compare client and counselor perceptions of clients' presenting problems within the structure of a counselor training clinic, which serves a large number of community residents presenting real life problems. Most studies to date have examined counselor and client presenting problem congruency in terms of broad diagnostic categories (i.e., Hurst et al., 1969); in relation to a special demographic variable (social class) (i.e., Balch & Miller, 1974); in relation to a special population (i.e., Tichenor, Thomas, & Kravetz, 1975); or through the rating of anticipated, fictitious clients (i.e., Cowan, Weiner, & Weiner, 1974). These researchers did not attempt, by and large, to examine this area of vital clinical interest in relation to actual mental health clients, presenting a heterogenous array of problems.

Strupp (1976) observed that therapists of most theoretical persuasions would be likely to agree that "the most significant measure of success [in therapy] is the elimination or substantial amelioration of the difficulties that brought the patient to therapy in the first place" (p. 9). Strupp (1976) further stated that "the therapist must be capable of understanding the messages that the patient is sending in distorted ways through his associations and his behavior in therapy, and he must be able to decode their meaning. He must understand something about the core of the patient's suffering as well as his contemporary struggles" (p. 21). It seems unfathomable that effective therapy can take place unless a client and counselor "match" regarding perception of the client's problem is achieved.

While previous researchers have underscored the importance of counselor-client presenting problem congruency on the process and outcome of therapy, few have attempted to identify

presenting problem categories within which congruency and incongruency are most likely to occur. This study was an attempt to do so.

Perennial Criterion Problem

One cannot approach this line of study without encountering the perennial criterion problem in counseling and psychotherapeutic process and outcome research. Inherent in an attempt to identify specific presenting problem areas, where client and counselor might find disagreement, is the possibility of overlap between categories used. The present study is intended to be an exploratory investigation into that particular aspect of counselor/client perceptions of clients' presenting problems. Though tempted to consider only existing, broad categories of client concerns (i.e., Hurst et al., 1969), it was decided that an expanded list of problem categories might reveal additional and/or more specific areas of counselor/client agreement or disagreement. Few researchers have attempted to identify specific presenting problem categories within which congruency and incongruency are most likely to occur.

The very title of Malan's (1973) article (The Outcome Problem in Psychotherapy Research) emphasizes his concern that research historically has had little impact on clinical practice, primarily because of "the failure to design outcome criteria that do justice to the complexity of human personality" (p. 728). Gelso (1979), in his major review of research in counseling, also argued that a wide variety of investigative strategies and research methods is appropriate and helpful and that the concept of relevance needs to be expanded to allow for the many possibilities of indirect relevance.

The search for "truth" is further complicated by the polarity of views represented by researchers espousing different theoretical orientations. The intake interview, for instance, might serve different purposes for therapists from each school. Various theorists also place contrasting emphases on the importance of process and outcome research being an exacting science. Extremists

at one end of this continuum would argue for research of a practical nature; those at the other end would argue for definitive conclusions or none at all. For instance, Carl Rogers (in Malan, 1973), representing a client-centered point of view, is quoted as saying, "he had never learned much from controlled studies and that his insights had come from clinical work" (p. 726). In direct contrast, Malan (1973) voiced confidence in Bergin's (1966) behaviorally-slanted article, "At last it seemed that the evidence in psychotherapy research, as in any other science, was converging toward definitive conclusions, and that the split between research and practice was beginning to be healed" (p. 721).

Strupp (1976) also notes the fundamental problem in trying to assess the effects of exceedingly complex human interactions between therapist and patient and underscores the perennial schism between researchers and practitioners:

> "To be sure, the practicing clinician as an applied scientist cannot wait until the researcher supplies him with all the answers he might need--this may never be possible. The exigencies of clinical practice are always such that he must do the best he can with the limited knowledge at his disposal. At the same time, however, he must be capable of tolerating considerable uncertainty, and he must see his techniques and his interventions and their theoretical underpinnings as tentative, provisional, and subject to modification in the light of emerging knowledge" (p. 4).

In view of the obvious differences of opinion concerning methods of approaching psychotherapy-related research and the application of those findings, it seems necessary to forge ahead and discover what we can with what we currently have at our disposal. This study is presented as an initial effort to identify areas of agreement and disagreement between counselors and clients regarding perceptions of the clients' presenting problems.

Method

Participants

Participants were 265 clients, age 16 and older, who had requested an intake interview at a midwestern university counselor training clinic. This clinic serves a general outpatient population of over 1,000 clients a year from this community and the surrounding area. University students, faculty, staff, and members of their immediate families are not seen at the clinic, as they have another counseling service available to them. While the results of this study may not be generalized to all clinics serving a general population throughout the United States, this population does seem reasonably representative.

Intake Counselors

Six advanced doctoral students were trained to serve as intake counselors. These students were completing the final weeks of their doctoral program in counseling psychology, including a supervised internship, at the time the study was conducted. Each also had at least two year's clinical experience before entering this post-master's doctoral program. For eleven weeks preceding the initiation of this research project, these doctoral students conducted intake interviews under the supervision of the senior researcher and an additional Ph.D. level counseling psychologist. These supervisors observed intakes, provided instruction regarding each student's intake sessions, carefully read their intake reports, and instructed them regarding any inconsistencies noted. Intake counselors had each conducted three or four intake interviews per week (33-44 total sessions) under these conditions before the study was initiated. Inconsistencies between intake counselors regarding either procedure or classification of problems were noted and altered as needed on succeeding intake interviews. The researchers feel that the intake counselors in this study, while not claiming to be "seasoned" therapists, were representative of competent psychologists in general in terms of therapeutic and diagnostic skills.

Procedure

Immediately prior to the intake interview, clients were asked to complete a checklist indicating their reason(s) for seeking counseling from among the following 24 potential problem areas: 1) depression, 2) suicidal thoughts, 3) anxiety (general), 4) anxiety (specific), 5) poor self-concept, 6) guilt feelings, 7) alcohol problems, 8) drug problems, 9) delusions or hallucinations (hearing sounds or seeing people or things around you which others do not hear or see, etc.), 10) problems thinking clearly, 11) occupation or job-related concerns, 12) decision-making problems, 13) academic or school concerns, 14) intrapersonal (inside myself) conflicts, 15) obsessive or compulsive problems (uncontrollable thoughts or need to continually repeat a behavior), 16) physical symptoms, 17) sexual concerns, 18) marital problems (husband and wife), 19) family problems (including children), 20) spouse abuse, 21) child abuse, 22) interpersonal (between people) problems, 23) dating relationships, and 24) grief or illness concerns.

Both "I don't know" and "other" categories were added so that clients, who were unable to identify a presenting problem, were not forced to do so and to allow clients to list problems not included by the researchers. Clients were instructed to check all categories that they felt were applicable to them. Only four of the 265 clients checked the "I don't know" category and none selected the "other" category, indicating that categories included in the study did encompass participants' concerns. These responses were not made available to the intake counselor until the intake interview was completed and intake counselors had indicated their perceptions of their client's presenting problem(s) on an identical checklist. Clients were instructed that the intake counselor was just that, an intake counselor only, and that, as soon as possible, the client would be assigned to a counselor who would see them on a regular basis.

Analysis

Since the data of the study is of a nominal nature, the binomial test, a nonparametric statistic (Conover, 1971), was used to ascertain the statistical significance of the frequencies of agreement between clients' and intake counselors' perceptions of presenting problems within the context of a hit vs. miss criterion. A presenting problem identified by both client and counselor can be considered a hit, while a presenting problem identified by only one of the two can be considered a miss. The requirement of the statistical analysis is to determine whether the number of hits for any given problem category is significantly above or below what would be expected by chance, given the possibility of two outcomes.

The assumptions for the binomial test are a) that each outcome is in either "class 1" or "class 2," but not both, b) that the n trials are mutually independent, and c) that each trial has probability p of resulting in the outcome "class 1," where p is the same for all n trials. All of these requirements are satisfied by the data of this study. The equation used sets a range with a lower and an upper limit, and any obtained frequency within this range can be considered due to chance. Conversely, any obtained frequency falling below the lower limit or above the upper limit permits one to reject the null hypothesis and to conclude that something other than chance may be operating.

The significance level is set by choosing equation multipliers of -1.96 (for the lower limit) and 1.96 (for the upper limit), if a .05 level of significance is desired, or -2.58 and 2.58 if a .01 level is desired. These are the z scores which include .025 and .005 of the two tails of a distribution for the respective significance levels. To provide a more concrete example, if -1.96 and 1.96 are chosen as the multipliers and the equation yields a lower limit of 12.12 and an upper limit of 24.88 for a given presenting problem category, and the obtained frequency for perception by both client and counselor is 25, one may reject the null hypothesis at the .05 level of significance. If -2.58 and 2.58 are chosen as the multipliers and they yield a lower limit of 9.95

and an upper limit of 26.33, then the obtained frequency of 25 would not permit one to reject the null hypothesis at the .01 level of significance.

Results

As can be seen in Table 1, marital problems and family problems are the only two categories which represented statistically significant counselor-client agreement, with agreement occurring in 64 and 66 percent of the cases respectively. Problem categories which represented a statistically significant miss (counselor-client disagreement) and which were endorsed to a greater degree by clients than by counselors were those labeled "anxiety (specific)" (only 14% agreement) and "problems thinking clearly" (only 6% agreement). Counselors were of the opinion that clients demonstrated significantly more "intrapersonal (inside myself) conflicts" (31% agreement) and "interpersonal (between people) problems" (28% agreement) than clients themselves identified.

Insert Table 1 About Here

Discussion

One issue raised by this study is that counselors were seldom aware of clients' problems "thinking clearly" or concerns regarding "specific anxiety." This lack of intake counselors' sensitivity to these aspects of clients' mental and emotional states has obvious implications for prospective clients' confidence in the counseling services to be offered. It would appear that, although intake counselors are in concert with clients regarding some types of problems which trouble clients, they might not be finely enough attuned to other possibly equally serious problems which clients may perceive in themselves.

Another interesting finding is the statistically significant lack of agreement between

counselors and clients in identifying "interpersonal problems" and "intrapersonal conflicts." If counselors and clients demonstrate agreement with respect to marital problems and family problems, why is there not also counselor and client agreement within the category labeled "interpersonal (between people) problems?" Are clients choosing to interpret interpersonal problems to mean persons other than their spouses or other family members?

Perhaps this result is an indication of the client's propensity to focus the source of conflict in another person. By indicating marital and/or family problems, clients may be maintaining the belief that the genesis of the problem rests with a spouse or a child. To indicate "interpersonal (between people) problems" indicts oneself in the search for a precipitating factor. Such an interpretation receives support from attribution theory (Hansen, 1984), which would predict that clients would tend to make situational attributions for their own behavior, while making dispositional attributions to explain the behavior of others. This may also serve to explain the significant counselor-only perception of "intrapersonal (inside myself) conflicts," since it would be difficult for clients to perceive a problem as inside themselves while making situational causal attributions.

However, it cannot be assumed that this discrepancy is due entirely to a client's attribution style, defenses, or lack of experience in interpersonal relationships. It is also possible that counselors' perceptions are distorted due to a lack of information or a misunderstanding of the client's problem. Although the interpretations of some of the observed results are not definitive, hopefully such research will begin to spotlight possible areas of counselor-client incongruency and will assist in delineating possible avenues for the continuation of this line of research.

Possibilities for Future Research

Future research directions might include a comparison of age groups to examine whether or not ages of either clients or counselors affect the frequency of agreement. Also, systematic

alteration of presenting problem categories and providing one or two sentence definitions could be instituted to assess the effect on counselor-client agreement or disagreement and to control for possible semantic difficulties. Measurement of the attribution styles of clients who mark both interpersonal problems and marital and/or family problems and those clients who mark only the latter could lead to an understanding of their method of assigning responsibility for problems.

It also is possible that perceptions of clients' problems might vary across theoretical orientations. Researchers interested in continuing this line of research could compare intake counselors trained to represent these various theoretical approaches. Differing counseling orientations may affect, directly or indirectly, therapists' ability to perceive clients' presenting problems. Some therapeutic approaches (e.g., behavioral, RET) are more goal-oriented, seek accountability, and may diagnose client problems early in the psychotherapeutic process. Others (i.e., existential, psychoanalytic-oriented therapy) are less goal-oriented and may, therefore, require more time before specific problems and therapeutic goals are established.

A longitudinal study comparing clients' and therapists' perceptions of the clients' presenting problems at the end of the intake session (as was done in this study), two or three sessions into therapy, and finally several sessions into therapy would seem warranted. Comparisons also might be made between genders and between groups differing in socioeconomic status.

Implications

Hopefully, continued research in this initial stage of client and counselor contact will illuminate where and how clients and counselors agree or differ in their perceptions of clients' presenting problems. The results of this exploratory study would appear to have important implications for compatible counselor and client goal setting and for effective treatment planning. As previously noted, prior research has stated that differing perceptions of presenting problems by clients and counselors can lead to different treatment goals for each party and may adversely affect

the counseling process as well as the outcome. Further clarification and application of such knowledge could facilitate improved service to clients and could enhance the preparatory training of counselors regarding specific problem areas presented by clients.

While previous researchers have underscored the importance of counselor-client presenting problem congruency on the process and outcome of therapy, few have attempted to identify presenting problem categories within which congruency and incongruency are most likely to occur. This study was an attempt to do so. In view of these results and the scarcity of related research conducted by practitioners in outpatient clinics serving a general population of clients, the need for additional study in this area is indicated.

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Table 1

Comparison of Intake Counselors' and Clients' Perceptions

of Clients' Presenting Problems

Note: Numbers in parentheses are frequencies; all others are percentages.

Presenting Problems	Perceived By Both Client and Counselor	Perceived By Client Alone	Perceived By Counselor Alone
Depression (115)	(53) 46	(48) 42	(14) 12
Suicidal Thoughts (22)	(8) 36	(13) 59	(1) 5
Anxiety (general) (69)	(28) 41	(19) 27	(22) 32
Anxiety (specific) (35)	(5) 14	(24) 69*	(6) 17
Poor Self-Concept (75)	(37) 49	(17) 23	(21) 28
Guilt Feelings (72)	(30) 42	(32) 44	(10) 14
Alcohol Problems (23)	(10) 43	(8) 35	(5) 22
Drug Problems (7)	(5) 71	(2) 29	(0) 0
Delusions/ Hallucinations (0)	(0) 0	(0) 0	(0) 0
Problems Thinking Clearly (32)	(2) 6	(29) 91*	(1) 3
Occupation/Job-related Concerns (48)	(23) 48	(14) 29	(11) 23
Decision-making Problems (67)	(25) 37	(30) 45	(12) 18
Academic/ School Concerns (18)	(4) 22	(12) 67	(2) 11
Intrapersonal (inside myself) Conflicts (99)	(31) 31	(21) 21	(47) 48*

(Table Continues)

Table 1 (cont.)

Comparison of Intake Counselors' and Clients' Perceptions of Clients' Presenting Problems

Presenting Problems	Perceived By Both Client and Counselor	Perceived By Client Alone	Perceived By Counselor Alone
Obsessive-compulsive (23)	(8) 35	(12) 52	(3) 13
Physical Symptoms (25)	(9) 36	(5) 20	(11) 44
Sexual Concerns (36)	(19) 53	(12) 33	(5) 14
Marital Problems (104)	(67) 64*	(10) 10	(27) 26
Family Problems (147)	(97) 66*	(15) 10	(35) 24
Spouse Abuse (29)	(10) 35	(5) 17	(14) 48
Child Abuse (11)	(7) 64	(2) 18	(2) 18
Interpersonal (between people) Problems (71)	(20) 28	(16) 23	(35) 94*
Dating Relationships (29)	(11) 38	(10) 34	(8) 28
Grief/Illness Concerns (26)	(10) 38	(14) 54	(2) 8

* $p < .01$